



Provider Participation Requirements (ARTS)

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Provider Participation Requirements (ARTS)

Updated: 1/19/2022

The Addiction and Recovery Treatment Services (ARTS) covered in this manual include: (i) medically managed intensive inpatient services (ASAM Level 4); (ii) substance use residential or inpatient services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); (iii) substance use intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5); (iv) opioid treatment services (opioid treatment programs and preferred office-based opioid treatment); (v) substance use outpatient services (ASAM Level 1.0); (vi) early intervention services (ASAM Level 0.5); (vii) substance use care coordination; (viii) substance use case management services; and (ix) withdrawal management services. This chapter provides general provider participation requirements and provider specific requirements for ARTS.

Provider requirements for additional Behavioral Health services covered by the Department of Medical Assistance Services (DMAS) are located in the Mental Health Services Manual, Psychiatric Services Manual, and Residential Treatment Services Manual located on the DMAS website at:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Providers are responsible for adhering to all DMAS policies, this manual, available on the DMAS website portal, their provider contracts with the Medicaid Managed Care Organization (MCOs) and the Behavioral Health Services Administrator (BHSA), and related state and federal regulations.

MANAGED CARE ENROLLED MEMBERS (ARTS)

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted MCOs and their network of providers. All providers must check Medicaid eligibility (Refer to Chapter 3) prior to rendering services and confirm whether an individual is enrolled in a Medicaid and which particular MCO.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility and MCO enrollment. Providers must register through the Virginia Medicaid

Web Portal in order to access this information. The Virginia Medicaid Web Portal can be



accessed by going to: www.viriniamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

There are several different managed care programs (Medallion 4.0, CCC Plus, and PACE) offered through DMAS for Medicaid individuals. To participate with one of the DMAS contracted managed care organizations, the provider must be credentialed and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. The links below provide more information on which MCOs participate in the managed care programs:

- Commonwealth Coordinated Care Plus (CCC Plus): <https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/>
- Medallion 4.0:
<https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/>
- Program of All-Inclusive Care for the Elderly (PACE):
 - For ARTS enrolled members under Medallion 4.0 and CCC Plus, PACE is provided by the individual's PACE Program.
<https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/>

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (ARTS)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the FFS behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a FFS provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider



issues; and perform utilization management including care coordination for the provision of Medicaid covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract or who have questions about credentialing/contracting process with

Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook, or contact Magellan of Virginia at 800-424-4536,

VAProviderQuestions@MagellanHealth.com, or visit the provider website at

<https://www.magellanprovider.com/MagellanProvider>.

Magellan of Virginia is responsible for enrollment and credentialing of FFS behavioral health providers based upon DMAS regulatory requirements.

The Magellan of Virginia Call Center has a centralized contact number **(1-800-424-4046)** for

Medicaid/FAMIS members and providers. The Call Center is located in Virginia and is available

24 hours a day, 365 days a year. Staff members include bilingual and multi-cultural representatives who speak English and Spanish. Interpreter services, TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1-800-424-4048.

All calls related to the fee-for-service behavioral health services should go to the Magellan of

Virginia Call Center. Magellan of Virginia staff members are available to assist callers with:

- service authorizations,

- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,
- claims resolution,
- reconsiderations,
- grievances and,
- complaints

MEDICAID PROGRAM INFORMATION (ARTS)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are members of a group using one central office may receive multiple copies of manual change notices, updates, and other publications sent by DMAS or its contractor unless the provider requests that publications not be mailed to them.

PARTICIPATING PROVIDER (ARTS)

A participating provider is an agency, program, institution, facility, or person that meets the standards and requirements set forth by DMAS and has a current, signed contract, and is successfully credentialed with the BHSA and/or a DMAS contracted MCO.

PROVIDER ENROLLMENT (ARTS)

To be a network provider of behavioral health services to serve members in the Virginia Medicaid/FAMIS programs, providers must be credentialed and enrolled according to DMAS standards with the BHSA and/or a Medicaid MCO. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the BHSA and/or a Medicaid MCO prior to rendering services. Please contact the BHSA or the Medicaid MCOs for additional information.

All participating Medicaid providers are required to complete a new contract agreement as

a result of any name change or change of ownership.

Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to DMAS or its contractors. Community Service Boards (CSBs)/ Behavioral Health Authorities (BHAs) and other agency based providers may use the organization NPI for purposes of billing.

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

PARTICIPATION REQUIREMENTS (ARTS)

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Behavioral Health providers approved for participation in the MCOs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify the MCOs and the BHSA in writing whenever there is a change in the information that the provider previously submitted, including adding new services, new service locations or changes in licensure. For a change of address, notify the MCOs and the BHSA prior to the change and include the effective date of the change;
- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS or its contactor require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.
- Per [42 CFR 431.51](#), providers must assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;
- Assure the individual's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national

origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS or its contractor for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;
- Accept as payment in full the amount reimbursed by DMAS or its contractor. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency....". The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses \$5.00 of an \$8.00 charge, and Medicaid's allowance is \$5.00, the provider may not attempt to collect the \$3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. This does not apply to copayments or coinsurance which is the responsibility of the member;
- The provider may not charge DMAS, its contractor or an individual for broken or missed appointments;
- Accept assignment of Medicare benefits for eligible Medicaid enrolled individuals;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;
- Use DMAS or its contractor designated billing forms for submission of charges;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided; In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Providers who are contracted with managed care organizations must follow their contract requirements for record retention.

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS or its contractor, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members;
- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public;
- Providers must comply with the Code of Virginia (§ 54.1-2400.4) mandate to inform their clients of the right to report misconduct to the Department of Health Professions.

ADVERSE OUTCOMES (ARTS)

ARTS providers must notify the BHSA or the appropriate MCO of member adverse outcomes or critical incidents within one business day following knowledge of the incident. The Critical Incident Report Form is located: <https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/>. Questions regarding the reporting of the critical incident may be directed to the BHSA or MCO.

Providers must follow notification or reporting processes required by applicable Local, State and Federal regulatory bodies or contracts with the MCOs and BHSA.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES (ARTS)

In order to comply with federal regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the person or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the

Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded person or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.



All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the person or business name, provider identification number (if applicable), and what, if any, action has been taken to date.

The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste. 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmass.virginia.gov

PROVIDER QUALIFICATIONS (ARTS)

To qualify as a provider of Medicaid ARTS, the provider of the services must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements; and
- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

Noted below are two (2) concepts that should also be reflected in all providers' service delivery practices.

1. RECOVERY AND RESILIENCY

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery-based behavioral health services for individuals enrolled in Virginia Medicaid. The federal Substance

Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations (<https://www.samhsa.gov/recovery>).

A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members. Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

A recovery focus is also a preventive approach that simultaneously supports building resiliency, wellness, measureable recovery and quality of life.

2. CULTURAL AND LINGUISTIC COMPETENCIES

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of

policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

In addition to the criteria stated above, a provider must meet the following requirements for ARTS.

PROVIDER CREDENTIALS FOR ARTS

The DMAS contracted MCOs and the BHSA work with DMAS to improve access to high quality ARTS services and improve the value of services purchased by the Commonwealth. The MCOs and the BHSA administer a comprehensive care coordination model, which is expected to provide high quality care to Medicaid and FAMIS members and reduce unnecessary and duplicative expenditures. Providers are subject to applicable Department of Health Professions (DHP), Virginia Department of Health (VDH), and DBHDS licensing requirements. Please note that obtaining a license through DBHDS and/or DHP does not guarantee credentialing and contracting with DMAS or its contractors.

Payments shall not be permitted to health care entities that either hold provisional DBHDS licenses or are not credentialed for each service site with the BHSA or Medicaid-contracted MCO prior to rendering that service.

All providers of the ARTS services listed below shall submit the appropriate ARTS

Attestation Credentialing Packet to the MCOs and the BHSA to initiate the credentialing process. The ARTS Attestation Forms and Staff Roster are posted online at: <https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/>.

- **ARTS Attestation Form for ASAM Level 2.1 to 4.0**, ARTS Staff Roster and copy of relevant licenses are required for the following:
 - ASAM Level 4.0: Medically Managed Intensive Inpatient Services; (DBHDS licensed only) *VDH Licensed Acute Care Hospitals are not required to submit an ARTS Attestation
 - Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7) (DBHDS licensed); and
 - Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5) (DBHDS licensed).

Providers are required to verify that they have the appropriate license for the service they are requesting based on the ASAM level.

This Medicaid provider manual contains instructions for billing and specific details concerning the Medicaid ARTS Program. Providers must comply with all sections of this manual, their contract and policies with the MCOs and the BHSA and related state and federal regulations to maintain continuous participation in the Medicaid Program.

RATE SETTING PROCESS FOR ARTS RESIDENTIAL TREATMENT PROVIDERS

All new Residential Treatment Facilities or providers adding on a new ASAM Level of Care for Residential Services (ASAM Level 3.3, 3.5 or 3.7) are required to file a pro-forma cost report for the determination of the initial rate. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the Residential Treatment Facility Rate do not include costs for drugs and professional (physician) services or primary/secondary/post-secondary education costs. The Residential Treatment Facility Rate cannot exceed \$423.32 per day. Drugs and professional services must be billed directly to the MCO, the DMAS contractors or DMAS directly, depending on the service and the member's benefit.

For more information about the pro-forma cost report, please see the May 28, 2021 Provider

Memo "Residential Treatment Facility Rate Changes - Effective July 1, 2021" on the DMAS provider portal: www.virginiamedicaid.dmas.virginia.gov.

SPECIFIC PROVIDER REQUIREMENTS (ARTS)

Addiction and Recovery Treatment Services

In addition to the following licensure requirements, substance use disorder treatment providers including outpatient physician and clinic services, intensive outpatient, partial hospitalization, residential treatment services and inpatient withdrawal management services (as defined in 12VAC30-130-5040 through 12VAC30-130-5150), must also be qualified by training and experience as defined in the American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related and Co-occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine. Any ASAM trainings completed by staff may be kept in their personnel file or records to support this requirement. The ASAM Criteria establishes standards for substance use/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.

In addition to following all general provider requirements outlined in this chapter, providers must also meet the applicable requirements listed below in addition to practicing within the scope of their license/certification/registration with DHP (i.e. Board of Medicine, Nursing, Counseling, Social Work, Psychology, etc.) Providers must have the knowledge, skills and abilities (KSAs) for substance use disorders (SUD) and treatment with applicable experience. Providers may obtain certification for SUD treatment to support having the KSAs, however certification is not required. Attendance in trainings, conferences, classes, etc. that staff participate in to increase their KSAs for SUD treatment and recovery may be kept in their personnel file or records to support this requirement.

Direct Supervision of Residents and Supervisees

When plans of care and psychotherapy or counseling services are provided by one of the following: "Residents" under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees

in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10), to support the billing of these services, the licensed supervisor must ensure that:

- Therapy or counseling sessions rendered by a Resident or Supervisee must be provided under the direct, personal supervision of a qualified, Medicaid enrolled provider.
- The therapy session must contain at a minimum the dated signature of the Resident or Supervisee rendering the service but also include the dated signature of the qualified, Medicaid enrolled, licensed supervising provider.
- Each therapy session must contain the dated co-signature of the supervising provider within three business days from the date the service was rendered indicating that they have reviewed the note. The direct supervisor can be the licensed program supervisor/manager for the agency.

Direct Supervision of Certified Substance Abuse Counselors (CSACs), CSAC-Supervisees and CSAC-Assistants

Providers shall follow the Board of Counseling scope of practice for CSACs, CSAC-Supervisees and CSAC-Assistants which is defined in the [Guidance Document 115-11](#). The Board of Counseling requires CSACs, CSAC-Supervisees and CSAC-Assistants to practice under supervision, also defined in the Guidance Document 115-11. In addition, when Medicaid reimbursable services are provided by a CSAC-Supervisee or CSAC-Assistant, the supervising provider shall co-sign and date the progress note entry within three business days from the date the service was rendered indicating that they have reviewed the note. CSACs and CSAC Supervisees are allowed to do the ASAM multidimensional assessment to make recommendations for a level of care as well as develop the individual service plan and must be signed off by a licensed professional.

SPECIFIC ASAM LEVEL OF CARE STAFFING REQUIREMENTS

These ARTS services, as defined by ASAM and DMAS policy, include the following:

- ASAM Level 4.0: Substance Abuse Medically Managed Intensive Inpatient for adults, children and adolescents;

- ASAM Level 3.7: Substance Abuse Medically Monitored Intensive Inpatient for adults, children and adolescents;
- ASAM Level 3.5: Substance abuse clinically managed high-intensity residential care for adults, children and adolescents;
- ASAM Level 3.3: Specific high-intensity residential service for adults;
- ASAM Level 3.1: Clinically managed low-intensity residential care for adults, children and adolescents;
- ASAM Level 2.5: Substance Abuse Partial Hospitalization service for adults, children and adolescents;
- ASAM Level 2.1: Substance Abuse Intensive Outpatient for adults, children and adolescents
- Opioid Treatment Programs (OTP) and Office Based Addiction Treatment (OBAT)*;
- Substance Use Outpatient Services (ASAM Level 1);
- Early Intervention Services / Screening Brief Intervention and Referral to Treatment (SBIRT) (ASAM 0.5);
- Substance Use Care Coordination;
- Substance Use Case Management Services, and
- Withdrawal Management services shall be provided when medically necessary, as a component of the following:
 - ASAM Level 4.0: Substance Abuse Medically Managed Intensive Inpatient for adults, children and adolescents;
 - ASAM Level 3.7: Substance Abuse Medically Monitored Intensive Inpatient for adults, children and adolescents;
 - ASAM Level 3.5: Substance abuse clinically managed high-intensity residential care for adults, children and adolescents;
 - ASAM Level 3.3: Specific high-intensity residential service for adults;
 - ASAM Level 2.5: Substance Abuse Partial Hospitalization service for adults, children and adolescents;
 - ASAM Level 2.1: Substance Abuse Intensive Outpatient for adults, children and adolescents
 - OTP and Preferred OBAT*; and
 - Substance Use Outpatient Services (ASAM Level 1).

*Preferred OBAT and OTP services are defined in a Supplement to this manual.

Medically Managed Intensive Inpatient Services (ASAM Level 4.0)
(H0011/rev.1002)

ASAM Level 4.0: Providers shall be licensed by VDH as an acute care general hospital which meet the conditions for participation under Title XVIII of Public Law 89-97 and are limited to an age group not eligible for Title XVIII benefits or by DBHDS as one of the following:

- Substance Abuse Medically Managed Intensive Inpatient for adults;
- Substance Abuse Medically Managed Intensive Inpatient for children and adolescents.

DBHDS licensed agencies must follow requirements set forth in 12VAC35-105-1430 through 12VAC35-105-1470. Acute care facilities are accredited by the Joint Commission on Accreditation for Hospitals and have a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review. ASAM Level 4.0 providers shall be the designated setting for medically managed intensive inpatient treatment and shall be contracted by the MCOs and the BHSA.

ASAM Level 4.0 providers shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and/or other drugs.

ASAM Level 4.0 shall meet these staff requirements:

1. An interdisciplinary staff of appropriately credentialed clinical staff including, for example, addiction-credentialed physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers shall assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or mental health disorders.
2. Medical management by physicians and primary nursing care shall be available 24 hours per day and counseling services shall be available 16 hours per day.

Co-Occurring Enhanced Programs

ASAM Level 4.0 co-occurring enhanced programs shall meet these staff requirements:

1. Credentialed Addiction Treatment Professionals who assess and treat the individual's co-occurring mental illness shall be knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.
2. Co-occurring programs shall be led by an Addiction-Credentialed Physician.

Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7) (H2036/rev 1002)

ASAM Level 3.7 programs provide a planned and structured regimen of 24 hours per day physician directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient/residential treatment center setting. They function under a defined set of policies, procedures, and clinical protocols.

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) services may be offered in freestanding, appropriately licensed facility located in a community setting, or a specialty unit in a licensed health care facility such as general or psychiatric hospital. ASAM Level 3.7 providers are contracted by the MCOs and the BHSA. Providers shall be licensed by DBHDS as one of the following license types:

- ASAM Level 3.7: Substance Abuse Medically Monitored Intensive Inpatient for adults;
- ASAM Level 3.7: Substance Abuse Medically Monitored High-Intensity Inpatient Services for children and adolescents.

Providers must meet the requirements set forth in 12VAC35-105-1480 through 12VAC35-105-1520.

ASAM Level 3.7 providers shall meet these staff requirements:

1. The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice and addiction-credentialed physicians or physicians with experience in addiction medicine to assess and diagnose, treat, and obtain and interpret information regarding the individual's psychiatric and substance use disorders.
2. Credentialed addiction treatment professionals shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Credentialed addiction treatment professionals shall be able to identify and diagnose acute psychiatric conditions, symptom increase or escalation, and decompensation. Credentialed addiction treatment professionals shall have specialized training in behavior management techniques and evidenced based best practices in working with individuals experiencing addiction.
3. Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intended to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavioral therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. Credentialed addiction treatment professionals personnel records should reflect having received training in behavior management techniques.
4. Credentialed addiction treatment professionals shall be able to provide a planned regimen of 24 hours per day professionally directed evaluation, care and treatment including the administration of prescribed medications.
5. An addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure the quality of care. Licensed physicians or physician extenders under supervision of a physician shall perform physical examinations for all individuals who are admitted within 24 hours of admission, except for instances when ASAM Level 3.7 is a step-down from ASAM Level 4.0 within the same facility, in which case records from the physical exam within the preceding 7 days should be evaluated by a physician within 24 hours of admission. The physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020, if knowledgeable about addiction treatment, shall have the ability to supervise addiction

pharmacotherapy, integrated with psychosocial therapies in addiction treatment.

Co-Occurring Enhanced Programs

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs as required by ASAM shall meet staff requirements as follows:

1. Psychiatrists and credentialed addiction treatment professionals who have specialized training in behavior management techniques as defined earlier in this chapter, and evidenced-based practices related to addiction and co-occurring conditions shall be available to assess and treat co-occurring psychiatric disorders.
2. Access to an addiction-credentialed physician shall be available 24 hours per day along with access to either a psychiatrist, a certified addiction psychiatrist, or a psychiatrist with experience in addiction medicine.
3. Credentialed addiction treatment professionals shall have experience and training in addiction and mental health to understand the signs and symptoms of mental illness and be able to provide education to the individual on the interaction of substance use and psychotropic medications.
4. Registered nurses and licensed practical nurses shall be available to provide care to and observation of individuals as defined in the individual service plan.

Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5) (H0010/rev 1002)

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) are residential treatment service providers who are contracted by the MCOs and the BHSA. Providers shall

be licensed by DBHDS as a provider of one of the following:

- ASAM Level 3.5: Clinically managed high-intensity residential care for adults;
- ASAM Level 3.5: Substance abuse clinically managed high-intensity residential care for children and adolescents.

Providers must meet the requirements set forth in 12VAC35-105-1530 through 12VAC35-105-1570.

Residential treatment providers (ASAM Level 3.5) shall meet these staff requirements:

1. The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice, physicians, or physician extenders and allied health professionals.
2. Staff shall provide 24 hours per day awake supervision on site.
3. Credentialed addiction treatment professionals shall be experienced in and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and be able to identify and diagnose acute psychiatric conditions and decompensation. Credentialed addiction treatment professionals shall have specialized training in relevant behavior management techniques and evidence-based best practices in working with individuals experiencing addiction.
4. Substance use case management shall be provided in this level of care to coordinate all services offered to each member. Note: Substance use case management services (H0006) are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.

5. Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intended to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavior therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.

6. Staff who are credentialed as addiction treatment professionals, physicians, or physician extenders shall be available on-site or by telephone 24 hours per day, seven days per week to respond to member treatment needs, assess and treat co-occurring biological and physiological disorders and to monitor the individual's administration of medications in accordance with a physician's prescription.

Co-Occurring Enhanced Programs

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs as required by ASAM shall have staff requirements as follows:

1. Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.
2. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness, and be able to provide education to the individual on the interactions with substance use and psychotropic medications. Credentialed addiction treatment professional staff shall be available on site or by telephone 24 hours per day and 7 days per week.
3. Staff shall provide 24 hours per day awake supervision on site. The provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-1530 and 12VAC35-46-1570.
4. Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3) (H0010/rev 1002)

Clinically managed population-specific high intensity residential services (ASAM Level 3.3) are facility-based providers and who are contracted with the MCOs and the BHSa. Providers shall be licensed by DBHDS as one of the following:

- ASAM Level 3.3: Specific high-intensity residential service for adults.

Providers must meet the requirements set forth in 12VAC35-105-1580 through 12VAC35-105-1620.

Residential treatment service providers for clinically managed population-specific high intensity residential services (ASAM Level 3.3) shall meet these staff requirements:

1. The interdisciplinary team shall include credentialed addiction treatment professionals acting within the scope of their practice, physicians, or physician extenders and allied health professionals in an interdisciplinary team.
2. Staff shall provide 24 hours per day awake supervision on site. The provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-1580.
3. Credentialed addiction treatment professionals shall be experienced and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and be available on-site or by telephone 24 hours per day. Clinical staff shall be able to identify and diagnose acute psychiatric conditions and decompensation.
4. Substance use case management is included in this level of care to coordinate all services offered to each member. Note: Substance use case management services (H0006) are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

Co-Occurring Enhanced Programs

Clinically managed population-specific high intensity residential service co-occurring enhanced programs, as required by ASAM, shall have staff requirements as follows:

1. Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.
2. Credentialed addiction treatment professionals shall be available to assess and treat co-occurring substance use and mental health disorders using specialized training in behavior management.
3. Credentialed addiction treatment professionals shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify and diagnose acute psychiatric conditions, symptom increase or escalation, and decompensation. Clinical staff shall have specialized training in relevant behavior management techniques and evidenced based best practices in working with individuals experiencing addiction.
4. Behavior management is used here as a generic phrase that includes a variety of behavioral intervention techniques that are intending to bring about positive behavioral changes. Behavioral management is a proactive approach to reducing disruptive and/or harmful behaviors. This includes but is not limited to: cognitive-behavior therapy, contingency contracting, contingency management, token economy, motivational enhancement therapy, crisis prevention, and other techniques. The clinical staff personnel records should reflect having received training in behavior management techniques.
5. Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) (H2034)

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) shall be contracted with the MCOs and BHSA. The provider shall be licensed by DBHDS as a provider of one of the following:

- ASAM Level 3.1: Clinically managed low-intensity residential care for adults;
- ASAM Level 3.1: Substance abuse clinically managed low-intensity residential care for children and adolescents.

Providers must meet the requirements set forth in 12VAC35-105-1630 through 12VAC35-105-1670.

Clinically directed program activities constituting at least five hours per week of professionally directed treatment shall be designed to stabilize and maintain substance use disorder symptoms and to develop and apply recovery skills. ASAM Level 3.1 clinically managed low intensity residential service providers shall meet these staff requirements:

1. Staff shall provide 24 hours per day awake supervision on site. In addition to this requirement, the provider's staffing plan must be in compliance with DBHDS staffing plan regulations set forth in 12VAC35-105-1630.
2. Allied health professional including qualified mental health professionals (QMHPs). Allied health professional means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.
3. Credentialed addiction treatment professionals shall be experienced and knowledgeable about the biopsychosocial and psychosocial dimensions and treatment of substance use disorders and able to identify the signs and symptoms of acute psychiatric conditions and decompensation.
4. An addiction-credentialed physician, physician with experience in addiction medicine, or physician extenders under supervision of a physician shall review the residential group home admission to confirm medical necessity for services, and a team of credentialed addiction treatment professionals shall develop and shall ensure delivery of the individual service plan.
5. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving ASAM Level 3.1 services in a group home setting.
6. Coordination with the member's primary care physician and other specialists shall occur as needed to review treatment and help align treatment plans among all treating practitioners.
7. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and appropriately trained staff to monitor the individual's administration of prescribed medications.

Co-Occurring Enhanced Programs

Clinically managed low intensity residential services (ASAM Level 3.1) co-occurring enhanced programs as required by ASAM shall have staff requirements as follows:

1. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness and to understand and be able to explain to the individual the purpose of psychotropic medications and interactions with substance use.
2. Access to an addiction credentialed physician shall be available for consultation as necessary.
3. Registered nurses and licensed practical nurses shall be available to provide care and observation to individuals as defined in the individual service plan.

Partial Hospitalization Services (ASAM Level 2.5) (S0201/rev 0913)

Partial Hospitalization Services (ASAM Level 2.5) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 20 hours per week and at least five service hours per service day of skilled treatment services with a planned format including individual and group counseling, medication management, family therapy, education groups, occupational and recreational therapy and other therapies. Withdrawal management services may be provided as necessary. Time not spent in skilled, clinically intensive treatment is not billable.

Partial hospitalization services (ASAM Level 2.5) providers shall be licensed by DBHDS as one of the following and contracted with the MCOs and the BHSA:

- Substance Abuse Partial Hospitalization service for adults;
- Substance Abuse Partial Hospitalization service for children and adolescents.

Providers must meet the requirements set forth in 12VAC35-105-1680 through 12VAC35-105-1720.

Partial hospitalization service providers shall meet the ASAM Level 2.5 support systems and staff requirements as follows:

1. An interdisciplinary team comprised of credentialed addiction treatment professionals acting within the scope of their practice and an addiction-credentialed physician, or

physician with experience in addiction medicine, or physician extenders as defined in 12VAC30-130-5020, shall be required.

2. Physicians shall have specialty training or experience, or both, in addiction medicine or addiction psychiatry. Physicians who treat adolescents shall have experience with adolescent medicine.
3. Program staff shall be cross-trained to understand signs and symptoms of mental illness and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.
4. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving partial hospitalization services.

Partial hospitalization services (ASAM Level 2.5) co-occurring enhanced programs shall have staff requirements as follows:

1. Credentialed addiction treatment professionals shall have experience assessing and treating co-occurring mental illness.
2. Clinical leadership and oversight shall be provided by an addiction credentialed physician or physician with experience in addiction medicine, or physician extender as defined in 12VAC30-130-5020.
3. Co-occurring programs shall provide case management for individuals with co-occurring mental illness who have unstable living environments or lack positive support systems conducive to recovery. Staff providing case management shall have training and experience working with individuals with a dual diagnosis in substance use and mental health disorders. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving partial hospitalization services.

Intensive Outpatient Services (ASAM Level 2.1) (H0015/rev 0906)

Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 3 service hours per service day to achieve an average of 9 to 19 hours of services per week for adults and an average of 6 to 19 hours of services per week for children and adolescents.

Intensive outpatient services (ASAM Level 2.1) shall be provided by providers/programs licensed by DBHDS as one of the following and contracted with the MCOs and the BHSA to provide this service.

- Substance Abuse Intensive Outpatient service for adults;
- Substance Abuse Intensive Outpatient for children and adolescents.

Providers must meet the requirements set forth in 12VAC35-105-1730 through 12VAC35-105-1770.

Intensive outpatient service providers shall meet the ASAM Level 2.1 staff requirements as follows:

1. An interdisciplinary team of credentialed addiction treatment professionals acting within the scope of their practice is required.
2. Generalist physicians or physicians with experience in addiction medicine are permitted to provide general medical evaluations and concurrent/integrated general medical care.
3. Staff shall be cross-trained to understand signs and symptoms of psychiatric disorders and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.
4. Emergency services, which shall be available, when necessary, by telephone 24 hours per day and seven days per week when the treatment program is not in session.
5. Direct affiliation with (or close coordination through referrals to) higher and lower levels of care and supportive housing services such as Clinically Managed Low Intensity Residential Services.

Co-Occurring Enhanced Programs

Intensive outpatient services (ASAM Level 2.1) co-occurring enhanced programs shall have staff requirements as follows:

1. Credentialed addiction treatment professionals shall have experience assessing and

treating co-occurring mental illness.

2. Clinical leadership and oversight, at a minimum, have capacity to consult with an addiction credentialed physician, or a physician with experience in addiction medicine, or a physician extender as defined in 12VAC30-130-5020

Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving intensive outpatient services.

Outpatient Substance Use Disorder Treatment Services (ASAM Level 1.0)

Outpatient substance use disorder treatment services shall be provided by a Credentialed Addiction Treatment Professional (CATP) as defined in 12VAC30-130-5020 under the scope of their practice and contracted by the MCOs or the BHSA to perform these services. Services can be provided in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, FQHCs, rural health clinics (RHCs), Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs), local health departments, and provider offices - private or group practices.

The ARTS specific procedure codes and reimbursement structure for outpatient services are posted online at:

<https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/> .

Outpatient services (ASAM Level 1) staff requirements include:

1. A CATP;
2. Providers who are licensed through DBHDS for ASAM Level 1.0 must meet the requirements set forth in 12VAC35-105-1780 through 12VAC35-105-1820.

Outpatient services (ASAM Level 1) co-occurring enhanced programs shall include:

1. Ongoing substance use case management for highly crisis prone individuals with co-occurring disorders. Substance use case management (H0006) by licensed DBHDS providers may be provided for members and reimbursed while receiving outpatient services.
2. Credentialed addiction treatment professionals who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor and manage individuals who have a co-occurring mental health disorder.

Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5) (99408 and 99409)

Early intervention (ASAM Level 0.5) settings for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services shall include health care settings such as: local health departments, FQHCs, RHCs, CSBs/ BHAs, health systems, emergency departments of hospitals, pharmacies, physician offices and private and group outpatient practices. Individual practitioners shall be licensed by DHP and either directly contracted by the MCOs and the BHSA to perform this level of care, or employed by organizations that are contracted by the MCOs and the BHSA.

Provider qualifications of SBIRT (ASAM Level 0.5) include: Physicians, pharmacists, and other credentialed addiction treatment professionals, within the scope of their practice, shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool, counseling and intervention to other clinical staff as allowed by their scope of practice, such as physicians delegating to a licensed registered nurse or licensed practical nurse. Billing of SBIRT must be through the licensed agency or provider who is credentialed with the MCO or BHSA.

Substance Use Case Management (H0006)

Substance Use Case Management services are for individuals who have a primary diagnosis of substance use disorder. Provider qualifications for a substance use case management shall meet the following criteria:

1. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements;
2. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;
3. The enrolled provider must be licensed by DBHDS as a provider of substance abuse case management services.
4. Substance use case management services shall be provided by a professional or professionals who meet at least one of the following criteria:
 - a. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least either 1) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or
 - b. Licensure by the Commonwealth as a registered nurse with at least either: 1) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder; or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or
 - c. Board of Counseling Certified Substance Abuse Counselor (CSAC), CSAC-Supervisee or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq. Community Service Boards that have CSACs, CSAC-Supervisees or CSAC-Assistants performing Substance Use Case Management Services shall be under supervision according to the supervision requirements of the Board of Counseling which allows for supervision by another person with substantially equivalent education, training, and experience, or such counselor shall be in compliance with the supervision requirements of a licensed facility, as long as the they are in compliance with the supervision requirements of the licensed facility (§54.1-3507.1 and §54.1-3507.2).

Peer Support Services

Collaborative, nonclinical, peer-to-peer services that engage, educate, and support a member's self-help efforts to improve their health, recovery, resiliency, and wellness to assist members in achieving sustained recovery from the effects of mental illness, addiction or both. Peer services are peer recovery support service that is a person centered, strength based, and recovery oriented rehabilitative service for members 21 years or older provided by a Peer Recovery Specialist (PRS).

A PRS is professionally qualified and trained to provide collaborative services to assist members in achieving sustained recovery from the effects of mental health, substance use disorders, or co-occurring disorders. A PRS who provides Peer Support Services is a self-identified person with lived experience with a mental health condition and/or substance use disorder who is in successful and ongoing recovery from mental health and/or substance use disorders and who is trained to offer support and assistance in helping others in the recovery and community-integration process.

Peer Support Specialist (PRS) shall meet the staff requirements as follows:

1. Have a high school diploma or equivalent;
2. Has completed the DBHDS peer recovery specialist training and holds a current certification by a certifying body approved by DBHDS;
3. Is registered with the Board of Counseling at the Department of Health Professions and
4. Is employed by or has a contractual relationship with a provider enrolled/credentialed with DMAS, its contractor, or a Medicaid MCO.

PROVIDER SCREENING REQUIREMENTS (ARTS)

All providers must now undergo a federally mandated comprehensive screening before their application for participation or contract is approved by the MCOs, the BHSA or DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every

provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table in the Exhibits of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and fingerprints. All other screening requirements excluding criminal background checks and fingerprints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers who are enrolling with DMAS or the BHSA and meet the provider types indicated in the Appendix of this Chapter are required to pay an application fee set forth in Section 1866(j)(2)(C) of the Social Security Act and 42 CFR 455.460. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in the Appendix section of this provider manual.** Providers shall refer to the specific MCOs for any additional requirements.

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS (ARTS)

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, the BHSA or DMAS.

Providers will receive written instructions from the MCOs, the BHSA or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS (ARTS)

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The Affordable Care Act (ACA) requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.



If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members, the provider must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Freedom of Choice (ARTS)

The member shall have freedom of choice in the selection of a provider of services. Generally, however, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS and are contracted and credentialed with the Medicaid MCOs and BHSA as required.

Requirements of Section 504 of the Rehabilitation Act (ARTS)

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for individuals with disabilities in the provider's programs or activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS (ARTS)

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability.

Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered individual. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security

Act for all eligible individuals covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid Program payments shall be made for an individual covered by Workers' Compensation.
- **Other Health Insurance** - When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of Medicaid enrolled individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.
- If there is an accident in which there is a possibility of third-party liability or if the individual reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to:

Third Party Liability Unit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

ASSIGNMENT OF BENEFITS (ARTS)

If a Virginia Medical Assistance Program beneficiary is the holder of an insurance policy which assigns benefits directly to the patient, **the hospital must require that benefits be assigned to the hospital or refuse the request for the itemized bill** that is necessary for the collection of the benefits.

Use of Rubber Stamps for Physician Documentation (ARTS)

For Medicaid purposes, a required physician signature may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric and substance use disorder services.

REVIEW AND EVALUATION (ARTS)

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. This function is handled by the Virginia Medical Assistance Program's Prepayment and Post payment Review Sections.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, DMAS, the MCOs or the BHSA may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician or pharmacy, or both, of his or her choice because of misutilization of Medicaid services.

Additional information on utilization review activities may be found in Chapter VI, Utilization Review and Control.

FRAUD (ARTS)

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals enrolled in Medicaid. A provider participation agreement will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter VI, "Utilization Review and Control" of this manual.

Termination of Provider Participation (ARTS)

DMAS, the MCOs or the BHSA may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS, the MCOs or the BHSA for services provided to members subsequent to the date specified in the termination notice.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the contracted MCO, BHSA, the DMAS Director and Conduent - Provider Enrollment Services (PES) 30 days prior to the effective date. The addresses are:



Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325 (D) and (E). The provider may appeal the decision in accordance with the Administrative Process Act (APA) (Virginia Code §2.2-4000 et seq.), the State Plan for Medical Assistance provided for in § 32.1-325 et seq. of the Code of Virginia and the DMAS appeal regulations at 12 VAC 30-20-500 et. seq. Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial. This only applies to provider contracts with DMAS for fee-for-service or the BHSA. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY (ARTS)

Section 32.1-325 (D) 2 of the Code of Virginia mandates that “Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony.” A provider convicted of a felony in Virginia or in any other state(s) must, within 30 days, notify DMAS, the MCOs or the BHSA of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

- 1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
- 2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action - means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal - means:

- 1) A member appeal is:
 - a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
 - b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

- 2) For services that have already been rendered, a provider appeal is:
- a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*; or
 - b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*

Internal Appeal - means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration - means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing - means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit - means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.



PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at <https://www.dmas.virginia.gov/appeals/>. From there you can fill out an informal appeal

request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
 - o Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - o Email to appeals@dmas.virginia.gov; or
 - o Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq.* and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in



the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Provider Risk Category Table

Provider Participation Requirements (ARTS)

Application	Rule Risk Category	App Fee Requirement Yes (Y) or No (N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(Inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate - Revalidating High - Newly Enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate - Revalidating High - Newly Enrolling	Y
Home Health Agency - Private Owned	Moderate - Revalidating High - Newly Enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate - Revalidating High - Newly Enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate - Revalidating High - Newly Enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Moderate - Revalidating High - Newly Enrolling	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

